State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2567
www.medbd.ca.gov

CHANGE OF ADDRESS FORM

Please fax to (916) 263-2944 or mail to
Medical Board of California, Division of Licensing, at the above address.
PLEASE PRINT CLEARLY ON ALL INFORMATION.

PHYSICIAN LICENSE NUMBER: _____

PHYSICIAN NAME:

_____ _____ _____
LAST FIRST (FULL) MIDDLE

CURRENT ADDRESS OF RECORD:

_____
_____
_____ _____ _____ _____
CITY STATE ZIP COUNTRY

PLEASE CHANGE MY ADDRESS OF RECORD TO:

_____
_____
_____ _____ _____ _____
CITY STATE ZIP COUNTRY

IF P.O. BOX IS USED, YOU MUST LIST A CONFIDENTIAL STREET ADDRESS:

_____
_____
_____ _____ _____ _____
CITY STATE ZIP COUNTRY

TELEPHONE NUMBER: **(PLEASE INCLUDE AREA CODE)**

_____ (The telephone number is not public information. It will only be used if there are questions regarding your request.)

_____
PHYSICIAN SIGNATURE & DATE

All above information MUST be included to complete your request. **Please allow only 32 characters per line for Address of Record.** Pursuant to B&P 2021(a)(b) your address of record is public information).